DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Acceptable w/ POC CE Stringer

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297123	A. BUILDING _____ B. WING _____	C 07/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA HOME HEALTH, LLC	801 SOUTH RANCHO DRIVE, SUITE A-2 LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey and complaint investigation conducted at your agency from July 18, 2008 through July 22, 2008. The active census at the time of the survey was 41. Fifteen clinical records were reviewed. Five home visits were conducted. One closed record was reviewed. One complaint was investigated. Complaint #NV15637 - Unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000	RECEIVED JAN 06 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA RECEIVED NOV 14 2008 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comply with accepted professional standards and principles for 1 of 15 sampled patients. Findings include:	G 121	TAG *121* A. Immediately after learning the failure of the visiting SN to observe proper BAG/universal precautions/appropriate wound care technique, the DON met and counselled the SN regarding the above. B. Dressing Change Policy and Proper Bag Technique reviewed and reinforced by DON to the staff last 08/08/08 staff meeting. See attached meeting Agenda. Attachment #1, TAG 121.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: RN

TITLE: DOPS

(X6) DATE: 11/12/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	Continued From page 1 Observation/Interview On 7/18/08 at 9:45 AM, the registered nurse (RN) failed to perform hand hygiene prior to reaching into her nursing bag to retrieve equipment. At 9:55 AM, the RN cleansed the the patient's lower left leg shin wound by wiping from approximately 2 centimeters on one side of the wound to the other side of the wound 3 times. On 7/18/08 at 4:30 PM, the Director of Nursing (DON) indicated she would expect the RN to perform hand hygiene each time prior to retrieving equipment from her nursing bag. The DON indicated she would expect the RN to cleanse the wound by starting from the center and moving outward in a circular motion. Document Review The Dressing Change Policy (undated) utilized by the facility indicated the nurse was to "Clean from the least contaminated area to the most contaminated area."	G 121	C. The HHA will incorporate review of appropriate wound care technique/dressing change policy/proper BAG technique in the HHA's annual schedule of inservices to the nursing staff as reinforcement to the instruction/training they received during their orientation period. See attached Orientation Checklist. Attachment #2, TAG 121. D. The DON/Nursing Supervisor will perform random/periodic monitoring of nursing staff's compliance and adherence to established Dressing Change Policy and proper BAG technique/universal precautions. E. Director of Nursing/Nursing Supervisor. F. Target Date of Completion: 11/21/08.	
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to provide documentation of summaries every 60 days for 3 of 15 patients (#2, #5, #14). Findings include: Record Review	G 145	TAG 145 A. Chart review done on patient's #2, #5, #14. 60 Day Summaries completed by respective staff and incorporated in patient's medical record as well as sent to MD's. See Attachment #3, TAG 145. B. The DON reviewed and reinforced to staff the HHA policy/procedure on completion of 60 Day Summary and timely submission of completed documentation to the office.	

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G 145	Continued From page 2 Patient #2's Plans of Care (POC) dated 04/17/08 to 06/15/08 and 06/16/08 to 08/14/08, did not contain written 60 day summaries. The OASIS Comprehensive Assessments dated 04/16/08 and 06/12/08, did not contain written 60 day summaries. Patient #2's chart lacked a 60 day summary form for two consecutive recertification periods. Patient #14's Plans of Care (POC) dated 04/15/08 to 06/13/08 and 06/14/08 to 08/12/08, did not contain written 60 day summaries. The Oasis Comprehensive Assessments dated 02/14/08, 04/12/08, and 06/14/08, did not contain written 60 day summaries. Patient #14's chart lacked a 60 day summary for two consecutive recertification periods. Document Review According to the agency's Clinical Record Submission Policy last updated 09/16/06, "all Oasis, Start of Care, Recertifications, and Discharge documentations must be turned in to the office within 48 hours after the completion of assessment. All other documents must be turned in on a weekly basis, on Mondays." On page 53 of the agency's policy manual, a section entitled Oasis Comprehensive Assessment states, "a 60 day summary must be completed and a copy must be sent to physician either by fax or mail...summary of care on OASIS form may be used in place of agency's 60 day summary form." Patient #5 was a 72 year-old female admitted on	G 145	That those documents need to be incorporated in patients medical records and sent to respective MD's in timely manner as well. This inservice was done last 08/08/08 staff's meeting. See Attachment #4, TAG 145. C. DON inserviced QA staff to be more conscientious on their record review and reinforce to staff importance of timely submission of documentations. QA staff will also inservice clinical staff on Standard regarding Coordination of Patient Services. D. DON/QA staff will perform periodic/random monitoring of clinical staff's compliance in this Standard. This can be achieved thru tracking of their submitted documents. See Attachment #5, TAG 145 – Tracking Sheet Forms. E. Responsible Person: DON/QA staff. F. Date of Completion: 10/31/08.	

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G 145	Continued From page 3 7/12/08 with diagnoses including Non-healing Surgical Wound, uncontrolled diabetes mellitus, joint pain and generalized muscle weakness. The clinical record for Patient #5 lacked documented evidence of a 60 day summary for the period ending 7/11/08. Interview On 07/18/08 in the afternoon, the Administrator failed to provide evidence of written 60 day summaries for Patients #2, #5 and #14. On 7/22/08 in the afternoon, the Director of Nursing indicated a copy of the physician summaries would be faxed. The requested documents were not received.	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, the agency failed to follow the plan of care for 3 of 15 sampled patients (#1, 5, 8). Findings include: Patient #1 Patient #1 was an 88 year-old female, admitted on 6/6/08, with diagnoses including Open Wound, Hypertension, Lumbago,Generalized Muscle Weakness and Difficulty Walking.	G 158	TAG 158 Patient #1 A. Clinical record review performed. Missed visit report not needed. An SN visit note was submitted and filed late on client's record. See attached copy of SN visit note. Attachment #6, TAG 158. B. DON inserviced QA staff to be more diligent on their record review and reinforce to the clinical staff re: policy/procedure on timely submission of documentations. Medical record personnel also inserviced on timely filing/incorporation of clinical records to client's chart.	

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G 158	Continued From page 4 Patient #1 had physician's orders to be seen by nursing every day during June 2008. The record lacked documented evidence of a skilled nursing visit on 6/21/08. The record lacked documented evidence the agency had notified the physician of the missed visit for 6/21/08. Patient #5 Patient #5 was a 72 year-old female admitted on 5/13/08, with diagnoses including Non-healing Surgical Wound, Uncontrolled Diabetes Mellitus, Generalized Muscle Weakness and Joint Pain. Patient #5 had a physician's order for physical therapy (PT) 2 times a week for 2 weeks for the week of 6/29/08. The clinical record lacked documented evidence PT had seen Patient #5 a second time during the week of 7/6/08. The clinical record lacked documented evidence the agency had notified the physician of the missed visit for the week of 7/6/08. On a Resumption of Care (ROC) physician's order, occupational therapy (OT) was ordered once a week for one week and 3 times a week for one week. The clinical record lacked documented evidence Patient #5 was seen by OT three times during the week of 6/21/08. The clinical record lacked documented evidence the agency had notified the physician of the missed visit for the week of 6/21/08. Patient #8 Patient #8 was a 91 year-old female admitted on 1/1/08, with diagnoses including Deep Vein Thrombosis, Long Term Anticoagulant Use and	G 158	C. Clinical Visit Tracker will track visits on daily basis and will call respective clinical staff who are deficient on their submission of documentations every Monday before the close of business. D. DON/QA staff will perform weekly monitoring of clinical staff's compliance to the policy of timely submission of clinical records. E. Responsible Person: DON/QA staff F. Date of Completion: 10/31/08. Patient #5 A. Chart review done. PT order was 2 times a week for 2 weeks for the week of 06/29/08. No evidence of missed visit note for the second visit for the week of 07/06/08. A missed visit note was not written because there was a PT visit done on 07/07/08. The visit note was submitted by the PT on 07/21/08 and was filed to client's chart after the Surveyor's visit. It was also said that this patient had an OT order for once week for one week and 3 times a week for one week during the ROC dated 05/21/08. Missed visit notes for week of 06/21/08 were not noted because there were actual OT visits done on the week of	

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G 158	Continued From page 5 Generalized Muscle Weakness. Patient #8 had a physician's order for skilled nursing (SN) visits once a week for 4 weeks. The clinical record lacked documented evidence showing a SN visit was done during the week of 2/24/08. The clinical record lacked documented evidence the agency had notified the physician of the missed visit for the week of 2/24/08.	G 158	06/21/08 according to MD's order dated 05/31/08 – OT for 2 times a week for 3 weeks. Again these submitted documentations were not submitted and filed in client's chart in timely manner. See attached PT/OT visit notes and signed MD order. Attachment #7, TAG 158.	
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review, the agency failed to administer drugs and treatments only as ordered by the physician for 7 of 15 patients (#1, #2, #3, #4, #5, #6, #8). Findings include: 1. Record Review Patient #2: Start of Care 06/22/07 - A medication profile dated 03/20/08 indicated Zocor 20 milligrams by mouth daily. - A physician's order dated 03/22/08 indicated Zocor 20 milligrams by mouth twice daily. - A Plan of Care for a recertification period dated 04/17/08 to 06/15/08 indicated Zocor 20 milligrams by mouth daily. - A medication profile dated 05/12/08 indicated Zocor 20 milligrams by mouth twice daily. - A medication profile dated 06/12/08 indicated Zocor 20 milligrams by mouth daily.	G 165	B. See Patient #1 POC. C. See Patient #1 POC. D. See Patient #1 POC. E. Responsible Person: DON/QA staff F. Date of Completion: 10/31/08. TAG 158 Patient #8 A. Patient #8 had an MD order for SN visit once a week for 4 weeks. No evidence of missed visit note noted on record review by Surveyor. Chart review done by QA staff and no missed visit note needed because an actual SN visit for Recertification of Care was done on 02/29/08. The completed documents were on file/incorporated in patient's chart during the record review under Care Plan/Assessment Section rather than on Nursing Visit Notes. See attached copy of Recertification OASIS Data dated 02/29/08. Attachment #8, TAG 158.	

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G 165	Continued From page 6 - A Plan of Care for a recertification period dated 06/16/08 to 08/14/08 indicated Zocor 20 milligrams by mouth daily. The chart lacked physician's orders changing the frequency of Zocor from twice daily to daily between 03/22/08 and 04/17/08, from daily to twice daily between 04/17/08 and 05/12/08, and from twice daily to daily between 05/12/08 and 06/12/08. Patient #4: Start of Care 09/02/06 - A physician's order dated 05/14/08, indicated Darvocet N-100 by mouth every 8 hours as needed for back pain. - A Plan of Care for a recertification period dated 06/23/08 to 08/21/08, failed to indicate Darvocet N-100 on its medication list. - The chart lacked a physician's order discontinuing Darvocet N-100 between 05/14/08 and 06/23/08. - A physician's order dated 06/25/08, indicated Levaquin 500 milligrams by mouth daily for 10 days and Medrol dose pack. A medication profile dated 06/21/08, failed to indicate the Levaquin or Medrol update. The chart failed to indicate if the patient received the Levaquin and the Medrol. Patient #6: Start of Care 06/14/07 - A Plan of Care for a recertification period dated 12/11/07 to 02/08/08, indicated Valium 10 milligrams by mouth daily, Topamax 200 milligrams by mouth three times daily, and Phenobarbital 65 milligrams by mouth three times daily. - A physician's order dated 12/29/07, indicated	G 165	B, C, D, E, F – No further action or POC needed. TAG 165 Patient #2 Start of Care 06/22/07 A. Medication Profile re: Zocor medication dose discrepancies/inconsistencies between 03/22/08 and 04/17/08, 04/17/08 and 05/12/08, and between 05/12/08 and 06/12/08. Chart review done. Discrepancies identified and corrected. Medication profile reconciled and updated. MD orders obtained, sent for signature and filed in patient's chart. See attached updated Medication Profile and signed MD orders. Attachment #9, TAG 165. B. QA staff inserviced about thorough and diligent chart review and importance of medication record reconciliation on 10/25/08. See attached Inservice/Training agenda. Attachment #10, TAG 165. C. DON/QA staff will conduct an inservice to clinical staff about importance of medication record reconciliation and Standard regarding administration of drugs and treatment in accordance to MD orders. QA	

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G 165	Continued From page 7 Valium 10 milligrams by mouth four times daily, Topamax 600 milligrams by mouth twice daily, and Phenobarbital 65 milligrams by mouth twice daily. - A medication profile dated 02/06/08, indicated Valium 10 milligrams by mouth three times daily, Topamax 600 milligrams by mouth twice daily, and Phenobarbital 65 milligrams by mouth twice daily as needed. A Plan of Care for a recertification period dated 02/09/08 to 04/08/08, indicated Valium 10 milligrams by mouth three times daily, Topamax 600 milligrams by mouth twice daily, and Phenobarbital 65 milligrams by mouth twice daily as needed. The agency discharged the patient 03/11/08. The chart lacked physician orders for any of the above changes. 2. Record Review and Interview Patient #1 was an 89 year-old female admitted on 6/6/08 with diagnoses including Open Lower Leg Wound and High Blood Pressure. A physician's order dated 7/10/08, indicated Patient #1 was to perform soaks to the left lower leg every 2 hours while awake. The order did not include what solution the patient was to use. The order did not indicate the patient or skilled nurse (SN) should continue with the current wound care until the new supplies were available. A nursing note by the SN dated 7/10/08 read, "Continue to apply Hydrogel to wound bed for now while new meds are not yet available."	G 165	staff has been performing continous chart review/quality improvement to ensure that medication records are updated and reconciled in timely manner since 10/25/08. D. DON/QA staff is monitoring compliance on this Standard through thorough review of submitted documentations in daily basis. E. Responsible Person: DON/QA staff F. Target date of completion: 11/22/08. TAG 165 Patient #4 Start of Care 09/02/06 A. MD order dated 05/14/08, indicated Darvocet-N 100 by mouth every 8 hours as needed for back pain. The Plan of Care for recert period dated 06/23/08 to 08/21/08 failed to list Darvocet-N 100 on its medication list. Chart review done. An MD order dated 05/28/08 was written, sent to MD for signature and received on 07/02/08 was not filed in the patient's chart in timely manner. Medication Profile updated accordingly. An MD order for Levaquin and Medrol dose pack dated 06/25/08 was noted but the medication profile was not	

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G 165	Continued From page 8 A nursing note dated 7/12/08, indicated the SN "Poured water into basin with Epsom salt . . ." On 7/18/08 at 4:40 PM, the director of nursing (DON) indicated the solution Patient #1 was to soak her leg in should have been included on the physician's order. Patient #3 Patient #3 was an 83 year-old female admitted on 7/11/08, with diagnoses including Difficulty Walking, Hypertension, Chronic Obstructive Pulmonary Disease and Generalized Muscle Weakness. Patient #3 was taking Lasix 20 milligrams by mouth every day (since 4/19/08). There was no physician's order for the patient to be taking Lasix. The patient's son indicated the patient took the Lasix only when needed for swelling in her lower extremities. Patient #5 Patient #5 was a 72 year-old female admitted on 5/13/08, with diagnoses including Non-healing Surgical Wound, Uncontrolled Diabetes Mellitus and Generalized Muscle Weakness. Medication issues - On 5/13/08, when Patient #5 was discharged from the acute care facility, three anti-diabetic medications (Amaryl, Actos and Metformin) had been discontinued. Patient #5 continued to take them, along with Insulin. On 5/16/08, Patient #5 had a blood sugar reading of 43. Wound care issues	G 165	updated accordingly. Upon identification of deficiency, medication profile was updated. See attached MD order and copy of updated medication profile. Attachment #11, TAG 165. B. QA staff/Medical Record Personnel counselled on importance of timely filing/incorporation of documentation to patient's chart. QA staff was counselled regarding thorough record review and accurateness of client's clinical record. C. Hiring and training of additional Medical Record Personnel if needed by 12/31/08. For the meantime, current administrative staff are utilized to assist Medical Record Personnel in filing documentations in patient's chart. An inservice to clinical staff regarding importance of medication profile reconciliation/update is scheduled at this time. See attached Inservice Agenda for 11/22/08. D. DON/QA staff will monitor in weekly basis status/volume of submitted documents that needs to be filed in client's chart. If there's increased amount of	

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G 165	Continued From page 9 - A physician's order dated 6/10/08 read, "DC (discontinue) previous wound care to abdominal area. New wound care . . . cleanse wound with NS (normal saline), pat dry, apply Hydrogel, top with thin layer of gauze moistened with NS, cover with dry 4 x 4 (gauze) and secure . . . QD. . . increase skilled nursing visit frequency to every day for 7 days." - A nursing note dated 6/12/08 read, "Cleaned with NS, patted dry and dry dressing applied." - A nursing note dated 6/14/08 read, "Cleansed wound with NS, patted dry, applied Hydrogel, covered with a 4 x 4 and secured with tape." - A nursing note dated 6/16/08 lacked documentation regarding wound care. The nursing note lacked a nurse's signature. Foley catheter issues - Patient #5 was discharged from the acute care facility with a Foley catheter, size 16 French with a 10 cc balloon. The clinical record lacked an order for Foley catheter changes and management. - A nursing note dated 6/12/08 read, "Foley cath changed today using sterile technique 18 French catheter . . . patient tolerated well." The genitourinary section of the note revealed the size was 18 French with a 20 cc balloon. - A nursing note dated 6/28/08 read, " . . . leaking. Removed old Foley cath that was in place and placed a new Foley catheter using sterile technique." The genitourinary section of the note revealed the size was 20 French with a 30 cc balloon. Patient #8 Patient #8 was 92 year-old female admitted on 1/1/08, with diagnoses including Deep Vein	G 165	material to be filed all administrative staff will assist MR personnel in filing. Pre-assigned division of materials i.e., A-Z last names of the patient is currently in place. See attached list. Attachment #12, TAG 165. E. Responsible Person: DON/QA Staff. F. Date of Completion: 11/22/08. TAG 165 Patient #6 Start of Care 06/14/07 A. MD order missing for changes in medication regimen. Chart review done. An MD order dated 01/28/08 was misfiled in another patient's chart and was found during chart review. See attached MD order dated 01/28/08. Attachment #13, TAG 165. B. QA staff/MR personnel counselled on importance of accurate and timely filing of MD orders and other documentations in patients chart. That all pertinent documentations should be on patient's file prior to final closure of patient's medical record. C. QA staff has to ensure that all pertinent materials filed in patient's chart are accurate and appropriate. This will be	

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G 165	Continued From page 10 Thrombosis, Long-term Use of Anticoagulant and Generalized Muscle Weakness. - The clinical record lacked documented evidence of a wound. The clinical record lacked evidence of a physician's order for wound care. Two nursing notes (dated 1/12/08 and 1/13/08) contained documentation about wound care that had been performed on Patient #8's left lower extremity by the nurse. - The clinical record lacked documented evidence of a physician's order to apply lotion to Patient #8's skin. Nursing notes (dated 1/9/08, 1/10/08, 1/12/08, 1/13/08, 1/17/08, 1/19/08 and 1/23/08) contained documentation about indicating the nurse had applied lotion to Patient #8's "dry skin."	G 165	achieved thru diligent chart review process. D. DON/QA staff will monitor this process on daily basis. Before archiving patient's medical records, QA Staff will ensure that all documentations on file are accurate and appropriate. E. Responsible Person: DON/QA staff. F. Date Completed: 10/22/08. TAG 165 Patient # 1 A. Incomplete MD order re: wound care. This discrepancy was already noted and corrected prior to this final report. See attached signed MD order. Attachment #14, TAG 165. B. MD orders have to be thoroughly checked prior to sending it for MD's signature. C. DON/QA staff will re-check every MD orders prior to sending it to MD for accuracy/completeness. D. Through diligent/thorough chart review in continous basis. E. Responsible Person: DON/QA staff. F. Date of Completion: 07/22/08.	
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to provide physician signatures on its Plan of Care (POC) for 1 of 15 patients (#2). Findings include: Patient #2	G 166		

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G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to provide physician signatures on its Plan of Care (POC) for 1 of 15 patients (#2). Findings include: Patient #2	G 166		

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G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to provide physician signatures on its Plan of Care (POC) for 1 of 15 patients (#2). Findings include: Patient #2	G 166		

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G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to provide physician signatures on its Plan of Care (POC) for 1 of 15 patients (#2). Findings include: Patient #2	G 166		

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G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to provide physician signatures on its Plan of Care (POC) for 1 of 15 patients (#2). Findings include: Patient #2	G 166	B, C, D, E, F - See comment on Wound Care Issues. Attachment #22, TAG 165. TAG 165 Patient #8 A. Missing documentation on presence of wound and wound care orders. As well as missing MD orders for lotion application to patient's dry skin. Chart review done. SN notes on 1/12/08 and 1/13/08 did reflect presence of wound on left lower extremity. A signed MD order dated 1/08/08 for Lotion application PRN for dry skin and 1/12/08 for wound care were evident but was not	

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G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to provide physician signatures on its Plan of Care (POC) for 1 of 15 patients (#2). Findings include: Patient #2	G 166	TAG 166 A. POC dated 06/16/08 to 08/14/08 was signed by MD and received by HHA in accordance to Standards and Agency's Policy for Patient #2 but was not yet incorporated in client's chart during record review. See attached signed POC. Attachment #25, TAG 165. B, C, D, E, F – See comment on Patient #4, TAG 165 re: importance of Timely filing of documents on clients medical records. Attachment #26, TAG 165.	

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G 166	Continued From page 11 Record Review A registered nurse signed Patient #2's POC dated 06/16/08 to 08/14/08 on 06/12/08. The physician failed to sign the plan as of 07/18/08, 33 days after the start of the certification. Document Review On page 45 of the agency's policy manual, a section entitled Physician's Plan Of Care/Orders states "consultation with the physician on the plan of care or any modification in the Plan of Care will be documented and the physician's signature obtained 30 days of the date of the order."	G 166		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the agency failed to provide documented supervisory visits every 14 days for home health aides for 3 of 15 patients (#4, #5, #12). Findings include: 1. Record Review Patient #4: Start of Care 09/02/06 The patient received twice weekly home health aide visits between 05/03/08 and 05/31/08 and weekly home health aide visits between 06/01/08	G 229	TAG 229 Patient #4, #12 A. Missing evidence of supervisory visits to home health aide. Supervisory visits were done and documented but was not submitted/incorporated in patient's medical records in timely manner. Respective clinical staff/QA staff/MR personnel counselled on timely submission and filing of documents in accordance to HHA policy and procedure. See attached copy of Supervisory visits. Attachment #27, TAG 229. B, C, D, E – See comment on Patient #4, TAG 165. Attachment #28, TAG 229.	

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G 229	Continued From page 12 and 07/05/08. Between 05/17/08 and 07/02/08, the patient received one home health aide supervisory visit on 06/06/08. Patient #12: Start of Care 01/31/07 The patient received twice weekly home health aide visits between 01/01/08 and 06/06/08. The chart lacked evidence of documented home health aide supervisory visits between 02/28/08 and 06/06/08. Document Review According to the agency's Clinical Record Submission Policy last updated 09/16/06, "all Oasis, Start of Care, Recertifications, and Discharge documentations must be turned in to the office within 48 hours after the completion of assessment. All other documents must be turned in on a weekly basis, on Mondays." Interview On 07/18/08 in the afternoon, the administrator failed to provide documentation of supervisory visits for Patients #4 and #12. 2. Record Review Patient #5 was a 72 year-old female admitted on 5/13/08 with diagnoses including Non-healing Surgical Wound, Uncontrolled Diabetes Mellitus and Generalized Muscle Weakness. The certified nurses aide (CNA) saw Patient #5 for personal care 3 times a week for 7 weeks, beginning 5/14/08. The second supervisory visit	G 229	Patient #5 A. Chart review done. According to our chart review, all Supervisory visits were done in accordance to Standards. See attached copy of Supervisory Visit done on 05/28/08, 06/09/08 and 06/20/08. Attachment #29, TAG 229. B. No further action needed. C. No further action needed. D. No further action needed. E. Date of Completion: 11/03/08.	

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G 229	Continued From page 13 was made on 6/20/08, 17 days after the previous supervisory visit.	G 229		